

# 2013 Leave Without Pay (LWOP) Continuation Coverage Election

- **Type or print clearly in black ink.** Inaccurate, incomplete, or illegible information may delay coverage.
- **We must receive your first payment before you can be enrolled.** (Make checks payable to the Washington State Treasurer.)
- List eligible family members you wish to cover or remove from coverage. This form replaces all *Leave Without Pay (LWOP) Continuation Coverage Election* forms previously submitted.
- If enrolling a dependent with a disability age 26 or older, or an extended dependent, you must attach the appropriate dependent certification form. Forms are available at [www.pebb.hca.wa.gov](http://www.pebb.hca.wa.gov) or by calling 1-800-200-1004.

## Qualifying event for Leave Without Pay coverage *Check only one.*

- |   |   |
|---|---|
| <input type="checkbox"/> Applying for disability retirement   | <input type="checkbox"/> Workers' compensation                  |
| <input type="checkbox"/> Layoff   | <input type="checkbox"/> Approved educational leave             |
| <input type="checkbox"/> USERRA (military) leave<br>Date called to duty in the uniformed services _____ | <input type="checkbox"/> Faculty between periods of eligibility |
| <input type="checkbox"/> Reversion employee   | <input type="checkbox"/> Seasonal employee off-season           |
| <input type="checkbox"/> Approved leave without pay (LWOP)  | <input type="checkbox"/> Employee appealing a dismissal action  |

## Section 1: Subscriber Information

Date employer coverage ended \_\_\_\_\_

Social security number	Last name	First name	Middle initial	Sex <input type="checkbox"/> M <input type="checkbox"/> F
Street address	Apt./unit number	City	State	ZIP Code
Mailing address (if different from above)	Apt./unit number	City	State	ZIP Code
County of residence	Date of birth (mm/dd/yyyy)	Daytime phone number ( )	Home phone number ( )	

- ☐ **Continue coverage** (select all that apply): ☐ Medical and dental ☐ Medical only ☐ Dental only ☐ Life Insurance  
☐ Long-term disability insurance (only if on educational or military leave)
- ☐ **Cancel coverage** I understand that I am forfeiting all further rights to enroll in PEBB benefits unless I regain eligibility.  
Reason \_\_\_\_\_ Cancel date \_\_\_\_\_

**If enrolled in Medicare Part(s) A and/or B, attach a copy of the Medicare card or entitlement letter to this form.**

## Section 2: Spouse or State-Registered Domestic Partner Information

List an eligible spouse or state-registered domestic partner you wish to cover or remove from coverage. Family members cannot be enrolled in two PEBB medical or dental accounts at the same time.

### Relationship to subscriber

<input type="checkbox"/> Spouse: date of marriage _____		<input type="checkbox"/> Domestic partner: date registered _____		
Social security number	Last name	First name	Middle initial	Sex <input type="checkbox"/> M <input type="checkbox"/> F
Street address (only if different from subscriber)	Apt./unit number	City	State	ZIP Code
Date of birth (mm/dd/yyyy)	<input type="checkbox"/> <b>Continue coverage</b> (select one): <input type="checkbox"/> Medical and dental <input type="checkbox"/> Medical only <input type="checkbox"/> Dental only <input type="checkbox"/> <b>Remove from coverage</b> Reason _____ Effective date _____			

**If enrolled in Medicare Part(s) A and/or B, attach a copy of the Medicare card or entitlement letter to this form.**

**2013 LWOP Continuation Coverage Election** *(continued)*

Subscriber's last name	First name	Middle initial	Social security number
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**Section 3: Family Member Information** (such as child) *Use additional forms for more members.*

List eligible family members you wish to cover or remove from coverage. Attach appropriate certification form(s) if enrolling a dependent with a disability age 26 or older, or an extended dependent. Family members cannot be enrolled in two PEBB medical or dental accounts at the same time.

<b>A</b>	Relationship to subscriber	Disabled? <input type="checkbox"/> Yes <input type="checkbox"/> No (Check only if age 26 or older.)	Sex <input type="checkbox"/> M <input type="checkbox"/> F	Social security number
Last name		First name	Middle initial	Date of birth (mm/dd/yyyy)
Street address (only if different from subscriber)		Apt./unit number	City	State ZIP Code
<input type="checkbox"/> Continue coverage (select one): <input type="checkbox"/> Medical and dental <input type="checkbox"/> Medical only <input type="checkbox"/> Dental only				
<input type="checkbox"/> Remove from coverage Reason _____ Effective date _____				
If enrolled in Medicare Part(s) A and/or B, attach a copy of the Medicare card or entitlement letter to this form.				
<b>B</b>	Relationship to subscriber	Disabled? <input type="checkbox"/> Yes <input type="checkbox"/> No (Check only if age 26 or older.)	Sex <input type="checkbox"/> M <input type="checkbox"/> F	Social security number
Last name		First name	Middle initial	Date of birth (mm/dd/yyyy)
Street address (only if different from subscriber)		Apt./unit number	City	State ZIP Code
<input type="checkbox"/> Continue coverage (select one): <input type="checkbox"/> Medical and dental <input type="checkbox"/> Medical only <input type="checkbox"/> Dental only				
<input type="checkbox"/> Remove from coverage Reason _____ Effective date _____				
If enrolled in Medicare Part(s) A and/or B, attach a copy of the Medicare card or entitlement letter to this form.				

**Section 4: Changes to an Existing Account****Are you making changes to an existing account?**

- ☐ Yes If yes, what changes? (Check all that apply in the sections below.)
- ☐ No If no, go to Section 5 on page 4.

**Changes you can make anytime**

Give date of event/change \_\_\_\_\_

- ☐ Name change ☐ Address change ☐ Cancel medical coverage ☐ Cancel dental coverage
- ☐ Remove dependent(s) from coverage. If removing due to loss of eligibility (divorce, dissolution of domestic partnership, death, or other loss of eligibility under PEBB rules), **you must submit this form no later than 60 days after the event.** If applicable, provide former dependent's new address:
- \_\_\_\_\_

**Additional changes you can make during annual open enrollment**

All changes become effective January 1 of the following year.

- Check the box(es) next to the change requested. ☐ Add dependent(s) ☐ Change medical plan ☐ Change dental plan
- (this section continued on next page)

**2013 LWOP Continuation Coverage Election** *(continued)*

Subscriber's last name	First name	Middle initial	Social security number
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**Section 4: Changes to an Existing Account** *(continued)***Additional changes you can make if an event creates a special open enrollment**

The PEBB Program allows changes outside of an annual open enrollment when an event creates a special open enrollment. The change must be on account of and correspond with an event that affects eligibility for coverage. You may be required to provide proof of the event that created the special open enrollment. **You must submit this form no later than 60 days after the event.** However, if adding a newborn or newly adopted child and the child increases your premium, you must submit this form no later than 12 months after the birth or adoption.

**Check the box next to the change(s) you are requesting, and indicate the corresponding event(s) below.**

See the numbers beside each change to verify your requested change may be allowed.

- ☐ **Add dependent(s)** (allowable under events 1, 2, 3, 4, 5, 6, 7, 9, 10)
- ☐ **Change medical and/or dental plan** (allowable under events 1, 2, 3, 4, 5, 8, 9, 10, 11, 12, 13)

Give date of event \_\_\_\_\_

**Check the box(es) next to the corresponding event(s).**

The event number must be listed next to the requested change(s) above.

- ☐ 1. Marriage, registering a domestic partner, birth, adoption, or assuming a legal obligation for total or partial support in anticipation of adoption.
- ☐ 2. Child becoming eligible as an extended dependent through legal custody or legal guardianship. *Also complete an Extended Dependent Certification form. Form available at [www.pebb.hca.wa.gov](http://www.pebb.hca.wa.gov).*
- ☐ 3. Child becoming eligible as a dependent with a disability. *Also complete a Certification of Dependent With a Disability form. Form available at [www.pebb.hca.wa.gov](http://www.pebb.hca.wa.gov).*
- ☐ 4. Subscriber or dependent losing other coverage under a group health plan or through health insurance, as defined by the Health Insurance Portability and Accountability Act (HIPAA).
- ☐ 5. Subscriber or dependent having a change in employment status that affects the subscriber's or dependent's eligibility for the employer contribution toward group health coverage.
- ☐ 6. Subscriber or dependent having a change in enrollment under another employer plan during its annual open enrollment that does not align with the PEBB Program's annual open enrollment.
- ☐ 7. Subscriber's dependent moving from outside the United States to live within the United States.
- ☐ 8. Subscriber or dependent having a change in residence that affects health plan availability.
- ☐ 9. A court order or National Medical Support Notice requires the subscriber or any other individual to provide insurance coverage for an eligible dependent of the subscriber.
- ☐ 10. Subscriber or dependent becoming eligible or losing eligibility for premium assistance through Medicaid or a state Children's Health Insurance Program (CHIP).
- ☐ 11. Subscriber or dependent becoming entitled to Medicare, or enrolling in or disenrolling from a Medicare Part D plan.
- ☐ 12. Subscriber or dependent's current health plan becoming unavailable because the subscriber or dependent is no longer eligible for a health savings account (HSA).
- ☐ 13. Subscriber or dependent experiencing a disruption of care that could function as a reduction in benefits for the subscriber or his or her dependent for a specific condition or ongoing course of treatment (requires PEBB approval).

Are you or any eligible dependents enrolled in PEBB coverage under another account? ☐ Yes ☐ No

*(continued)*

**2013 LWOP Continuation Coverage Election** *(continued)*

Subscriber's last name	First name	Middle initial	Social security number
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**Section 5: Medical Plan Selection** *Check only one.*

Contact plans for benefits information; their contact information is located at the end of this form.

**Group Health Cooperative**

- ☐ Group Health Classic  
☐ Group Health Value

**Group Health Options Inc.**

- ☐ Group Health Consumer-Directed Health Plan

**Kaiser Foundation Health Plan of the Northwest**

- ☐ Kaiser Permanente Classic  
☐ Kaiser Permanente Consumer-Directed Health Plan

**Uniform Medical Plan, administered by Regence BlueShield**

- ☐ UMP Classic  
☐ UMP Consumer-Directed Health Plan

**Section 6: Dental Plan Selection** *Check only one.*

Contact plans for benefits information; their contact information is located at the end of this form.

**Preferred Provider Organization**

- ☐ Uniform Dental Plan, administered by Washington Dental Service (Group #3000)  
(may receive services from any provider)

**Managed-Care Plans**

- ☐ DeltaCare, administered by Washington Dental Service (Group #3100)  
Dentist name or clinic code

\_\_\_\_\_ (must receive services from a DeltaCare provider)

- ☐ Willamette Dental of Washington, Inc.  
Clinic location

\_\_\_\_\_ (must receive services from a Willamette Dental Group provider)

**Section 7: Life and Accidental Death & Dismemberment (AD&D) Insurance****Current Enrollment With Agency**

- ☐ Basic Employee Life and AD&D  
(\$4.08/month guaranteed through December 31, 2013)

- ☐ Supplemental Employee Life

- ☐ Basic Spouse/State-Registered Domestic Partner Life

- ☐ Basic Children Life

- ☐ Supplemental Spouse/State-Registered Domestic Partner Life

- ☐ Supplemental Employee AD&D

- ☐ Include Supplemental AD&D for dependents

- ☐ Do not include Supplemental AD&D for dependents

**Coverage Amount**

\$ 25,000 Life / \$ 5,000 AD&D

\$ \_\_\_\_\_

\$ 2,500

\$ 2,500 per child

\$ \_\_\_\_\_

\$ \_\_\_\_\_

**Desired Enrollment While Self-Paying**

- ☐ I wish to maintain the same coverage I had as an active employee. \_\_\_\_\_ (initials)

- ☐ I do not wish to continue the life coverage while eligible for self-pay; I understand that I must reapply and submit evidence of insurability to reinstate optional life insurance when I return to work. \_\_\_\_\_ (initials)

**2013 LWOP Continuation Coverage Election** *(continued)*

Subscriber's last name	First name	Middle initial	Social security number
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**Section 8: Long-Term Disability**

This section applies **only** to employees on approved educational leave or called to active duty in the uniformed services as defined under the Uniformed Services Employment and Reemployment Rights Act (USERRA).

**Current Enrollment With Agency**

- ☐ **Basic coverage** (\$2.00/month)      ☐ **Optional coverage** *(select a waiting period)*
- |                                 |                                  |                                  |                                  |
|---------------------------------|----------------------------------|----------------------------------|----------------------------------|
| <input type="checkbox"/> 30-Day | <input type="checkbox"/> 90-Day  | <input type="checkbox"/> 180-Day | <input type="checkbox"/> 300-Day |
| <input type="checkbox"/> 60-Day | <input type="checkbox"/> 120-Day | <input type="checkbox"/> 240-Day | <input type="checkbox"/> 360-Day |

**Desired Enrollment While Self-Paying**

- ☐ I wish to maintain the same coverage I had as an active employee. \_\_\_\_\_ *(initials)*
- ☐ I do not wish to maintain the same coverage I had as an active employee. \_\_\_\_\_ *(initials)*

**Section 9: Signature** *Required*

I have received and read the *Continuation of Coverage Election Notice* including any appendices. By signing this form, I declare that the information I have provided is true, complete, and correct. If it isn't, or if I do not update this information within the timelines in PEBB rules, to the extent permitted by federal and state law, I must repay any claims paid by my health plan(s). My family members and I may also lose PEBB benefits as of the last day of the month we were eligible. To the extent permitted by law, PEBB may retroactively terminate coverage for me and my dependents if I intentionally misrepresent eligibility, or do not fully pay premiums when due. In addition, I understand that knowingly providing false, incomplete, or misleading information to an insurance company for the purpose of defrauding the company is a crime, and can result in imprisonment, fines, and denial of PEBB benefits.

If adding a domestic partner to my account, I declare that my partner and I have registered through the Washington Secretary of State's Office or another state.

If I send payment, this does not mean that I will be automatically enrolled in PEBB insurance coverage. The PEBB Program will verify eligibility for me and my family members. If we do not qualify, I will receive a refund.

If I am enrolling in a consumer-directed health plan with a health savings account (HSA), I must meet HSA eligibility conditions. I understand that the PEBB Program will direct a portion of my monthly premium to an HSA on my behalf based on the information I have provided, and that there are limits to these contributions and my HSA contributions (if any) under federal tax law.

This form replaces all *Leave Without Pay Continuation Coverage Election* forms I have previously submitted to PEBB.

**HCA's Privacy Notice:**

We will keep your information private as allowed by law. To receive our Privacy Notice, call 360-725-0442 or go to [www.hca.wa.gov](http://www.hca.wa.gov).

Subscriber's signature \_\_\_\_\_ Date \_\_\_\_\_

**Please sign and date this form.**

**Mail to:**

Washington State Health Care Authority, P.O. Box 42684, Olympia, WA 98504-2684

**If payment is enclosed, mail to:**

Washington State Health Care Authority, P.O. Box 42695, Olympia, WA 98504-2695

**Or hand-deliver to:**

Washington State Health Care Authority, 626 8th Ave. SE, Olympia, WA 98501

### **2013 PEBB MEDICAL CONTRACTORS**

**Group Health Cooperative**, 320 Westlake Ave. N., Suite 100, Seattle, WA 98109-5233  
**1-888-901-4636 or TTY 1-800-833-6388**

**Group Health Options Inc.**, 320 Westlake Ave. N, Suite 100, Seattle, WA 98109-5233  
**1-888-901-4636 or TTY 1-800-833-6388**

**Kaiser Foundation Health Plan of the Northwest**, 500 NE Multnomah St., Suite 100, Portland, OR 97232-2099  
**1-800-813-2000 or TTY 1-800-735-2900**

**Uniform Medical Plan, administered by Regence BlueShield**, P.O. Box 2998, Tacoma, WA 98401-2998  
**1-888-849-3681 or TTY 711**

### **2013 PEBB DENTAL CONTRACTORS**

**DeltaCare, administered by Washington Dental Service**, 9706 Fourth Avenue NE, Seattle, WA 98115-2157  
**1-800-650-1583**

**Uniform Dental Plan, administered by Washington Dental Service**, 9706 Fourth Avenue NE, Seattle, WA 98115-2157  
**1-800-537-3406**

**Willamette Dental of Washington, Inc.**, 6950 NE Campus Way, Hillsboro, OR 97124-5611  
**1-855-433-6825**

### **2013 PEBB LIFE INSURANCE CONTRACTOR**

**ReliaStar Life Insurance Company**, P.O. Box 20, Route 7325, Minneapolis, MN 55440-0020 (Policy Form #LP00GP)  
**1-866-689-6990**

### **2013 PEBB LONG-TERM DISABILITY INSURANCE CONTRACTOR**

**Standard Insurance Company**, 411 108th Ave. NE, Suite 400, Bellevue, WA 98004  
**1-800-368-2860**